DO NOT STAPLE

New Hampshire
Department of
Revenue Administration

DP-153

0DP1531911862

Medicaid Enhancement Tax Return

Tax Period Begin Date MMDDYYYY

Tax Period End Date MMDDYYYY

STEP 1 - PRINT OR TYPE

Name of Hospital

Taxpayer Identification Number

Number & Street Address

Hospital Fiscal Year End Date

Address (continued)

City / Town

State

Zip Code + 4 (or Canadian Postal Code)

STEP 2 - Type of Return (check if applicable)

☐ Initial Return (1st filing) ☐ Amended Return ☐ Final Return Last Day of Business

STEP 3 - Calculate Your Balance Due or Overpayment

Round to the nearest whole dollar

1. Gross Charges: (a) Inpatient Hospital Services	1(a)	
(b) Outpatient Hospital Services	1(b)	
Total Gross Charges (Sum of Lines 1(a) and 1(b))	1	
2. Net Excluded Charges for Outpatient Hospital Services from attached schedule Line 21	2	
3. Subtotal (Line 1 minus Line 2)	3	
4. Deductions: (a) Bad Debts	4(a)	
(b) Charity Care	4(b)	
(c) Payor Discounts	4(c)	
Total Deductions (Sum of Lines 4(a), 4(b), and 4(c))	4	
5. Net Patient Services Revenue (Line 3 minus Line 4)	5	
6. New Hampshire Medicaid Enhancement Tax (Line 5 multiplied by applicable tax rate)	6	0
7. Credits: (a) Credit Carryover from prior tax period	7(a)	
(b) Payment made with original return (Amended returns only)	7(b)	
Total Credits (Sum of Lines 7(a) and 7(b))	7	
8. Balance of Tax Due (Line 6 less Line 7)	8	0

MAIL TO: NH DRA, ADMINISTRATION UNIT, PO BOX 637, CONCORD, NH 03302-0637
Enclose, but do not staple or tape your payment with the return

New Hampshire
Department of
Revenue Administration

DP-153

0DP1531921862

MEDICAID ENHANCEMENT TAX RETURN

STEP 3 - Calculate Your Balance Due or Overpayment - continued

9. Additions:		
(a) Interest	9(a)	
(b) Failure to Pay Penalty	9(b)	
(c) Failure to File Penalty	9(c)	
Total Additions (Enter the sum of Lines 9(a), 9(b), and 9(c))	9	
10. Balance Due (Line 8 plus Line 9)	10	0
11. Overpayment: Enter balance due if less than zero	11	0
12. Apply overpayment to:		
(a) Credit - Next Year's Tax Liability	12(a)	
(b) Refund	12(b)	0

STEP 4 - Signatures

Under penalties of perjury, I declare that I have examined this return and to the best of my belief it is true, correct and complete. If prepared by a person other than the person owning or operating the utility, this declaration is based on all information of which the preparer has knowledge.

Signature of Officer (in ink)

MMDDYYYY

Print Signatory Name & Title

Phone Number

Signature of Preparer

MMDDYYYY

Printed Name of Preparer

Preparers Tax Identification Number

Preparer's Address

Phone Number

Address (continued)

City / Town

State

Zip Code + 4 (or Canadian Postal Code)

MAIL TO: NH DRA
ADMINISTRATION UNIT
PO BOX 637
CONCORD NH 03302-0637

Make Check Payable to:

STATE OF NEW HAMPSHIRE